

APPENDIX 1

Text of nine Rules proposed for amendment:

11 NCAC 23A .0108

11 NCAC 23A .0109

11 NCAC 23A .0302

11 NCAC 23B .0104

11 NCAC 23B .0105

11 NCAC 23L .0101

11 NCAC 23L .0102

11 NCAC 23L .0103

11 NCAC 23L .0105

1 11 NCAC 23A .0108 is proposed for amendment as follows:

2
3 **11 NCAC 23A .0108 ELECTRONIC FILINGS WITH THE COMMISSION; HOW TO FILE**

4 (a) All documents filed with the Commission in workers' compensation cases shall be submitted electronically in
5 accordance with this Rule. Any document transmitted to the Commission in a manner not in accordance with this Rule
6 shall not be accepted for filing. Any document filed with the Commission that requires contemporaneous payment of
7 a processing fee pursuant to Rule 11 NCAC 23E .0203 shall not be deemed filed until the fee has been paid in full.
8 The electronic filing requirements of this Rule shall not apply to ~~employees, medical providers,~~ employees or non-
9 insured employers without legal representation. ~~Employees, medical providers,~~ Employees and non-insured
10 employers without legal representation may file all documents with the Commission via the Commission's Electronic
11 Document Filing Portal ("~~EDFP~~"), ("EDFP") or by sending the documents to the Clerk of the Industrial Commission
12 via electronic mail, mail (dockets@ic.nc.gov), facsimile, U.S. Mail, private courier service, or hand delivery.

13 (b) Except as set forth in Paragraphs (d) and (e) of this Rule, all documents required to be submitted electronically to
14 the Commission shall be filed ~~transmitted to the Commission~~ via EDFP. Information regarding how to register for and
15 use EDFP is available at <http://www.ic.nc.gov/training.html>. In the event EDFP is inoperable, all documents required
16 to be filed via EDFP shall be transmitted to the Commission via electronic mail to edfp@ic.nc.gov. Documents
17 required to be filed via EDFP that are sent to the Commission via electronic mail when EDFP is operable shall not be
18 accepted for filing.

19 (c) Transcripts of depositions shall be filed with the Commission pursuant to this Rule by the court reporting service.
20 Transcripts filed with the Commission shall have only one page of text per page and shall include all exhibits. The
21 parties shall provide the Commission's court reporting service with the information necessary to effectuate filing of
22 the deposition transcripts and attached exhibits via EDFP. If an exhibit to a deposition is in a form that makes
23 submission of an electronic copy impracticable, counsel for the party offering the exhibit shall make arrangements
24 with the Commission to facilitate the submission of the exhibit. Condensed transcripts and paper copies of deposition
25 transcripts shall not be accepted for filing.

26 (d) A Form 19 shall be filed as the first report of injury (FROI) via electronic data interchange (EDI), except in claims
27 involving non-insured ~~employers~~ employers, ~~or~~ in claims for lung disease, in claims with multiple employers or
28 multiple carriers, or in claims with six-character IC file numbers, in which case the Form 19 shall be filed electronically
29 via EDFP to forms@ic.nc.gov, by mail to 1235 Mail Service Center, Raleigh, North Carolina 27699-1235, or as
30 otherwise permitted pursuant to Paragraph (a) of this Rule. Information regarding how to register for and use EDI is
31 available at www.nciedi.info.

32 ~~(e) The workers' compensation forms and documents listed in Table 1 shall not be required to be transmitted via~~
33 ~~EDFP provided all applicable qualifying conditions are met.~~

34
35 Table 1: Forms and documents exempt from EDFP filing requirements and how to file them:

36

DOCUMENT	QUALIFYING CONDITION(S)	HOW TO FILE
----------	-------------------------	-------------

Form 18	No IC file number has been assigned	Electronically to forms@ic.nc.gov, by mail to 1235 Mail Service Center, Raleigh, North Carolina 27699-1235, or as otherwise permitted pursuant to Paragraph (a) of this Rule
Form 18B	Always exempt from EDFP filing requirement	Electronically to forms@ic.nc.gov, by mail to 1235 Mail Service Center, Raleigh, North Carolina 27699-1235, or as otherwise permitted pursuant to Paragraph (a) of this Rule
Form 51	Always exempt from EDFP filing requirement	Electronically to forms@ic.nc.gov
Plaintiff's Attorney Representation Letter	No IC file number has been assigned	Electronically to forms@ic.nc.gov
Documents to be filed with the Commission's Compliance & Fraud Investigative Division	Always exempt from EDFP filing requirement	Electronically to fraudecomplaints@ic.nc.gov or as otherwise permitted pursuant to Paragraph (a) of this Rule
Documents to be filed with the Commission's Medical Fees Section	Always exempt from EDFP filing requirement	Electronically to medicalfees@ic.nc.gov or as otherwise permitted pursuant to Paragraph (a) of this Rule
Documents to be filed with the Commission's Safety Education & Training Section	Always exempt from EDFP filing requirement	Electronically to safety@ic.nc.gov or as otherwise permitted pursuant to Paragraph (a) of this Rule
A Form 25N to be filed with the Commission's Medical Rehabilitation Nurses Section	No IC file number has been assigned	Electronically to 25N@ic.nc.gov
Rehabilitation referrals to be filed with the Commission's Medical Rehabilitation Nurses Section	No IC file number has been assigned	Electronically to rehab.referrals@ic.nc.gov

- 1
- 2 (e) Documents to be filed with the Criminal Investigations & Employee Classification Division regarding fraud
- 3 complaints shall be submitted electronically to fraudcomplaints@ic.nc.gov. Documents to be filed with the Criminal

1 Investigations & Employee Classification Division regarding employee misclassification shall be submitted
2 electronically to emp.classification@ic.nc.gov. Safety rules to be filed with the Commission under 11 NCAC 23A
3 .0411 shall be submitted electronically to safety@ic.nc.gov.

4 (f) A self-insured employer, carrier or guaranty association, third-party administrator, court reporting service, medical
5 provider, or law firm may apply to the Commission for an emergency temporary waiver of the electronic filing
6 requirement set forth in Paragraph (a) of this Rule when it is unable to comply because of temporary technical
7 problems or lack of electronic mail or internet access. The request for an emergency temporary waiver shall be
8 included with any filing submitted via facsimile, U.S. Mail, or hand delivery due to such temporary technical or access
9 issues.

10 (g) A Notice of Appeal to the North Carolina Court of Appeals shall be accepted for filing by the Commission via
11 ~~EDFP or U.S. Mail.~~ EDFP, U.S. Mail, hand delivery, or any other means allowed by the Rules of Appellate Procedure
12 or applicable statutes governing appeals from the General Courts of Justice. Notwithstanding the foregoing,
13 employees and non-insured employers without legal representation may file all documents with the Commission as
14 provided in Paragraph (a) of this Rule.

15

16 *History Note: Authority G.S. 97-80; 97-81; 97-86;*

17 *Eff. February 1, 2016;*

18 *Amended Eff. February 1, 2017;*

19 *Recodified from 04 NCAC 10A .0108 Eff. June 1, 2018;*

20 *Amended Eff. December 1, 2018;*

21 *Amended Eff. _____.*

22

23

1 11 NCAC 23A .0109 is proposed for amendment as follows:

2

3 **11 NCAC 23A .0109 CONTACT INFORMATION**

4 (a) "Contact information" for purposes of this Rule shall include telephone number, facsimile number, email address,
5 and mailing address.

6 (b) All attorneys of record with matters before the Commission shall inform the Commission ~~in writing~~ of any change
7 in the attorney's contact information via ~~email to dockets@ic.nc.gov~~, the Commission's Electronic Document Filing
8 Portal ("EDFP").

9 (c) All unrepresented persons or entities with matters before the Commission shall inform the Commission upon any
10 change to their contact information in the following manner:

11 (1) All employees who are not represented by counsel shall inform the Commission of any change in
12 contact information by filing a written notice via ~~EDFP, the Commission's Electronic Document~~
13 ~~Filing Portal ("EDFP")~~, email to forms@ic.nc.gov, facsimile, U.S. Mail, private courier service, or
14 hand delivery.

15 (2) All non-insured employers that are not represented by counsel shall inform the Commission of any
16 change in contact information by filing a written notice via EDPF, email to dockets@ic.nc.gov,
17 facsimile, U.S. Mail, private courier service, or hand delivery.

18

19 *History Note: Authority G.S. 97-80;*
20 *Eff. January 1, 2019;*
21 *Amended Eff. _____.*

22

23

1 11 NCAC 23A .0302 is proposed for amendment as follows:

2

3 **11 NCAC 23A .0302 REQUIRED CONTACT INFORMATION FROM CARRIERS**

4 All insurance carriers, third party administrators, and self-insured employers shall designate a primary contact person
5 for workers' compensation issues in North Carolina and shall maintain and provide annually on July 1 to the Director
6 of Claims Administration of the Commission via the Commission's Electronic Document Filing Portal ("EDFP")
7 ~~email at rule302@ic.nc.gov~~, the primary contact person's current contact information, including direct telephone and
8 facsimile numbers, mailing addresses, and email addresses. Contact information shall be updated within 30 days of
9 any change.

10

11 *History Note: Authority G.S. 97-80(a); 97-94;*
12 *Eff. January 1, 2011;*
13 *Amended Eff. November 1, 2014;*
14 *Recodified from 04 NCAC 10A .0302 Eff. June 1, 2018;*
15 *Amended Eff. December 1, 2018;*
16 *Amended Eff. _____.*

17

18

1 11 NCAC 23B .0104 is proposed for amendment as follows:

2
3 **11 NCAC 23B .0104 ELECTRONIC FILINGS WITH THE COMMISSION; HOW TO FILE**

4 (a) All filings to the Commission in tort claims shall be submitted electronically in accordance with this Rule. Any
5 document transmitted to the Commission in a manner not in accordance with this Rule shall not be accepted for filing.
6 Plaintiffs without legal representation may file all documents with the Office of the Clerk of the Commission via the
7 Commission's Electronic Document Filing Portal (~~EDFP~~), (~~EDFP~~) or by sending the documents to the Clerk of the
8 Industrial Commission via electronic mail, mail (dockets@ic.nc.gov), facsimile, U.S. Mail, private courier service, or
9 hand delivery.

10 (b) ~~Except as set forth in Paragraph (c) of this Rule, all documents shall be transmitted to the Commission via EDFP.~~
11 Information regarding how to register for and use EDFP is available at <http://www.ic.nc.gov/training.html>. In the
12 event EDFP is inoperable, all documents required to be filed via EDFP shall be transmitted to the Commission via
13 electronic mail to edfp@ic.nc.gov. Documents required to be filed via EDFP that are sent to the Commission via
14 electronic mail when EDFP is operable shall not be accepted for filing.

15 (c) ~~The tort claims forms and documents listed in Table 1 shall not be required to be transmitted via EDFP provided~~
16 ~~all applicable qualifying conditions are met.~~

17
18 Table 1: ~~Forms and documents exempt from EDFP filing requirements and how to file them:~~

DOCUMENT	QUALIFYING CONDITION(S)	HOW TO FILE
Form T-1	No IC file number has been assigned	Hand delivery to the Industrial Commission's main office or by mail to 1236 Mail Service Center, Raleigh, North Carolina 27699-1236.
Form T-3	No IC file number has been assigned	Email to dockets@ic.nc.gov , hand delivery to the Industrial Commission's main office, or by mail to 1236 Mail Service Center, Raleigh, North Carolina; 27699-1236
Pre-affidavit motion under Rule 9(j)(3) of the Rules of Civil Procedure to extend the Statute of Limitations.	No IC file number has been assigned.	Hand delivery to the Industrial Commission's main office or by mail to 1236 Mail Service Center, Raleigh, North Carolina 27699-1236.

19
20 (d) ~~A one year waiver shall be granted to an attorney who notifies the Commission of the attorney's inability to~~
21 ~~comply with the electronic filing requirements in Paragraph (a) of this Rule due to a lack of the necessary internet~~
22 ~~technology resources. The notification shall indicate why the attorney is unable to comply with the rule and outline~~
23 ~~the attorney's plan for coming into compliance within the one year period. The notification shall be filed with the~~
24 ~~Office of the Clerk of the Commission via facsimile or U.S. Mail. This Paragraph shall expire one year from the~~
25 ~~effective date of this Rule.~~

1 ~~(c)~~ (e) Any party may apply to the Commission for an emergency temporary waiver of the electronic filing
2 requirement set forth in Paragraph (a) of this Rule if it is unable to comply because of temporary technical problems
3 or lack of electronic mail or internet access. The request for an emergency temporary waiver shall be included with
4 any filing submitted via facsimile, U.S. Mail, or hand delivery due to such temporary technical or access issues.

5 ~~(d)~~ (f) A Notice of Appeal to the North Carolina Court of Appeals shall be accepted for filing by the Commission via
6 ~~EDFP or U.S. Mail.~~ EDFP, U.S. Mail, hand delivery, or any other means allowed by the Rules of Appellate Procedure
7 or applicable statutes governing appeals from the General Courts of Justice. Notwithstanding the foregoing, plaintiffs
8 without legal representation may file all documents with the Commission as provided in Paragraph (a) of this Rule.

9
10 *History Note:* Authority G.S. 143-291; 143-291.2; 143-293; 143-297; 143-300;
11 *Eff. May 1, 2000;*
12 *Amended Eff. July 1, 2014;*
13 *Recodified from 04 NCAC 10B .0104 Eff. June 1, 2018;*
14 *Amended Eff. March 1, 2019;*
15 *Amended Eff. _____.*
16
17

1 11 NCAC 23B .0105 is proposed for amendment as follows:

2

3 **11 NCAC 23B .0105 CONTACT INFORMATION**

4 (a) "Contact information" for purposes of this Rule shall include telephone number, facsimile number, email address,
5 and mailing address.

6 (b) All persons or entities without legal representation who have matters pending before the Commission shall advise
7 the Commission upon any change in contact information by filing a written notice via the Commission's Electronic
8 Document Filing Portal ("EDFP"), electronic ~~mail~~ mail (dockets@ic.nc.gov), facsimile, U.S. Mail, private courier
9 service, or hand delivery.

10 (c) A plaintiff without legal representation who was an inmate in the North Carolina Division of Adult Corrections at
11 the time of filing his or her tort claim, shall, within thirty (30) days of release, provide the Commission with written
12 notice of his or her post-release contact information in any manner authorized in Paragraph (b) of this Rule. Following
13 the initial written notice of post-release contact information, the previously incarcerated plaintiff shall continue to
14 advise the Commission upon all changes in contact information in accordance with Paragraph (b) of this Rule.

15 (d) All attorneys of record with matters before the Commission shall inform the Commission in writing of any change
16 in the attorney's or the represented party's contact information via ~~email to dockets@ic.nc.gov~~ EDFP.

17

18 *History Note: Authority G.S. 143-291; 143-300;*

19 *Eff. March 1, 2019;*

20 *Amended Eff. _____.*

21

22

1 11 NCAC 23L .0101 is proposed for amendment as follows:

2
3 **SUBCHAPTER 23L – INDUSTRIAL COMMISSION FORMS**

4
5 **SECTION .0100 – WORKERS’ COMPENSATION FORMS**

6
7 **11 NCAC 23L .0101 FORM 21 – AGREEMENT FOR COMPENSATION FOR DISABILITY**

8 ~~(a) (Effective until July 1, 2015) The parties to a workers' compensation claim shall use the following Form 21,~~
9 ~~Agreement for Compensation for Disability, for agreements regarding disability and payment of compensation~~
10 ~~therefor pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of~~
11 ~~compensation for permanent partial disability may also be included on the form. This form is necessary to comply~~
12 ~~with Rule 11 NCAC 23A .0501, where applicable. The Form 21, Agreement for Compensation for Disability, shall~~
13 ~~read as follows:~~

14
15 ~~North Carolina Industrial Commission~~
16 ~~Agreement for Compensation for Disability~~
17 ~~(G.S. 97-82)~~

18
19 ~~IC File # _____~~
20 ~~Emp. Code # _____~~
21 ~~Carrier Code # _____~~
22 ~~Carrier File # _____~~
23 ~~Employer FEIN _____~~

24
25 ~~The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act~~

26
27 _____
28 ~~Employee's Name~~
29 _____
30 ~~Address~~
31 _____
32 ~~City _____ State _____ Zip _____~~
33 _____
34 ~~Home Telephone _____ Work Telephone _____~~
35 ~~Social Security Number: _____ Sex: M F Date of Birth: _____~~
36
37 _____

1 Employer's Name _____ Telephone Number _____

2 _____

3 Employer's Address _____ City _____ State _____ Zip _____

4 _____

5 Insurance Carrier _____

6 _____

7 Carrier's Address _____ City _____ State _____ Zip _____

8 _____

9 Carrier's Telephone Number _____ Carrier's Fax Number _____

10 _____

11 We, The Undersigned, Do Hereby Agree And Stipulate As Follows:

12 1. _____ All parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and
13 _____ is the carrier/administrator for the employer.

14 2. _____ The employee sustained an injury by accident or the employee contracted an occupational disease arising out
15 of and in the course of employment on or by _____.

16 3. _____ The injury by accident or occupational disease resulted in the following injuries: _____
17 _____.

18 4. _____ The employee was / was not paid for the entire day when the injury occurred.

19 5. _____ The average weekly wage of the employee at the time of the injury, including overtime and all allowances,
20 was \$ _____, subject to verification unless otherwise agreed upon in Item 9 below.

21 6. _____ Disability resulting from the injury or occupational disease began on _____.

22 7. _____ The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of
23 \$ _____ per week beginning _____, and continuing for _____ weeks.

24 8. _____ The employee has / has not returned to work for _____
25 on _____, at an average weekly wage of \$ _____.

26 9. _____ State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial
27 disability: _____.

28 10. _____ If applicable, the Second Injury Fund Assessment is \$ _____. Check is is not attached.

29 11. _____ The date of this agreement is _____. Date of first payment: _____ Amount: _____.

30 12. _____ IMPORTANT NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agreement
31 is \$300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your portion of
32 the fee in advance, and if your award is \$3,000.00 or less, you are not responsible for any portion of the fee. If your
33 award is more than \$3,000.00, the employer shall deduct \$150.00 from your award, unless you and your employer
34 agree otherwise.

35 Check one of the boxes below if the award is more than \$3,000.00:

36 The employer will deduct \$150.00 from the amount to be paid pursuant to this agreement.

37 The employee and employer have agreed that the employer will pay the entire fee.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36

Name Of Employer _____ Signature _____ Title

Name Of Carrier / Administrator _____ Signature _____ Title

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Pages 1 and 2 of this form.

Signature of Employee _____ Address

Signature of Employee's Attorney _____ Address

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

Claims Examiner _____ Date

Attorney's Fee Approved

- Check Box If No Attorney Retained.
- Check Box If Employee Is In Managed Care.

~~IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS~~

~~Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.~~

~~IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS~~

~~If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.~~

1 ~~IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL~~
2 ~~MEDICAL BENEFITS~~

3 ~~If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several~~
4 ~~factors. Your right to payment of future medical compensation will terminate two years after your employer or~~
5 ~~carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think~~
6 ~~you will need future medical compensation, you must apply to the Industrial Commission in writing within two years,~~
7 ~~or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M, Employee's~~
8 ~~Application for Additional Medical Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>.~~

9
10 ~~IMPORTANT NOTICE TO EMPLOYER~~

11
12 ~~The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC~~
13 ~~23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or~~
14 ~~carrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the~~
15 ~~agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical~~
16 ~~Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.~~

17
18 ~~NEED ASSISTANCE?~~

19
20 ~~If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at~~
21 ~~(800) 688-8349.~~

22
23 ~~Form 21~~

24 ~~11/2014~~

25
26 ~~Self-Insured Employer or Carrier, Mail to:~~

27 ~~NCIC - Claims Section~~

28 ~~4335 Mail Service Center~~

29 ~~Raleigh, NC 27699-4335~~

30 ~~Telephone: (919) 807-2502~~

31 ~~Helpline: (800) 688-8349~~

32 ~~Website: <http://www.ic.nc.gov/>~~

33
34 ~~(a) (Effective July 1, 2015) The parties to a workers' compensation claim shall use the following Form 21, *Agreement*~~
35 ~~for Compensation for Disability, for agreements regarding disability and payment of compensation therefor pursuant~~
36 ~~to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent~~

1 partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501,
2 where applicable. The Form 21, *Agreement for Compensation for Disability*, shall read as follows:

3
4 North Carolina Industrial Commission
5 Agreement for Compensation for Disability
6 (G.S. 97-82)

7
8 IC File # _____
9 Emp. Code # _____
10 Carrier Code # _____
11 Carrier File # _____
12 Employer FEIN _____

13
14 The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

15
16 _____

17 Employee's Name
18 _____

19 Address
20 _____

21 City State Zip
22 _____

23 Home Telephone Work Telephone
24 Last 4 digits of Social Security Number: _____ Sex: M F Date of Birth: _____

25
26 _____

27 Employer's Name Telephone Number
28 _____

29 Employer's Address City State Zip
30 _____

31 Insurance Carrier
32 _____

33 Carrier's Address City State Zip
34 _____

35 Carrier's Telephone Number Carrier's Fax Number
36

37 We, The Undersigned, Do Hereby Agree And Stipulate As Follows:

1 1. All parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and
2 _____ is the carrier/administrator for the employer.

3 2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out
4 of and in the course of employment on or by _____.

5 3. The injury by accident or occupational disease resulted in the following injuries: _____
6 _____.

7 4. The employee was/ was not paid for the entire day when the injury occurred.

8 5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances,
9 was \$ _____, subject to verification unless otherwise agreed upon in Item 9 below.

10 6. Disability resulting from the injury or occupational disease began on _____.

11 7. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of
12 \$ _____ per week beginning _____, and continuing for _____ weeks.

13 8. The employee has / has not returned to work for _____
14 on _____, at an average weekly wage of \$ _____.

15 9. State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial
16 disability: _____.

17 10. If applicable, the Second Injury Fund Assessment is \$ _____. Check is is not attached.

18 11. The date of this agreement is _____. Date of first payment: _____ Amount: _____.

19 _____
20 _____

21 Name Of Employer Signature Title
22 _____

23 Name Of Carrier / Administrator Signature Title
24 _____

25 By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on
26 Page 2 of this form.

27 _____
28 Signature of Employee Address

29 _____
30 Signature of Employee's Attorney Address

31
32 North Carolina Industrial Commission
33 The Foregoing Agreement Is Hereby Approved:
34 _____

35 Claims Examiner Date
36 _____

37 Attorney's Fee Approved

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37

- Check Box If No Attorney Retained.
- Check Box If Employee Is In Managed Care.

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must apply to the Industrial Commission in writing file an application for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M, Employee's Application for Additional Medical Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>. An application for additional medical compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission forms are available at <https://www.ic.nc.gov/forms.html>.

IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial ~~Commission~~ Commission, or show cause for not ~~submitting the agreement~~. The employer or carrier/administrator shall file a Form 28B, *Report of Compensation and*

1 *Medical Compensation Paid*, within 16 days after the last payment made pursuant to this agreement or be subject to
2 a penalty.

3

4 NEED ASSISTANCE?

5

6 If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at
7 (800) 688-8349.

8

9 Form 21

10 7/2015-7/2020

11

12 Self-Insured Employer or Carrier, File via Electronic Document Filing Portal (“EDFP”);~~Carrier, Mail to:~~

13 ~~NCIC – Claims Section~~

14 ~~4335 Mail Service Center~~

15 ~~Raleigh, NC 27699-4335~~

16 ~~Telephone: (919) 807-2502~~

17 ~~Helpline: (800) 688-8349~~

18 ~~Website: <http://www.ic.nc.gov/>~~

19 <https://www.ic.nc.gov/docfiling.html>

20 Contact Information:

21 NCIC- Claims Administration

22 Telephone: (919) 807-2502

23 Helpline: (800) 688-8349

24 Website: <https://www.ic.nc.gov>

25

26 (b) The copy of the form described in Paragraph (a) of this Rule can be accessed at
27 <http://www.ic.nc.gov/forms/form21.pdf>~~https://www.ic.nc.gov/forms/form21.pdf~~. The form may be reproduced only
28 in the format available at ~~http://www.ic.nc.gov/forms/form21.pdf~~ <https://www.ic.nc.gov/forms/form21.pdf> and may
29 not be altered or amended in any way.

30

31 *History Note:* Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;

32 Eff. November 1, 2014;

33 Recodified from 04 NCAC 10L .0101 Eff. June 1, 2018;

34 Amended Eff. _____.

35

36

1 11 NCAC 23L .0102 is proposed for amendment as follows:

2

3 **11 NCAC 23L .0102 FORM 26 – SUPPLEMENTAL AGREEMENT AS TO PAYMENT OF**
4 **COMPENSATION**

5 ~~(a) (Effective until July 1, 2015) If the parties to a workers' compensation claim have previously entered into an~~
6 ~~approved agreement on a Form 21, Agreement for Compensation for Disability, or a Form 26A, Employer's Admission~~
7 ~~of Employee's Right to Permanent Partial Disability, they shall use the following Form 26, Supplemental Agreement~~
8 ~~as to Payment of Compensation, for agreements regarding subsequent additional disability and payment of~~
9 ~~compensation pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of~~
10 ~~compensation for permanent partial disability may also be included on the form. This form is necessary to comply~~
11 ~~with Rule 11 NCAC 23A .0501, where applicable. The Form 26, Supplemental Agreement as to Payment of~~
12 ~~Compensation, shall read as follows:~~

13

14 North Carolina Industrial Commission
15 Supplemental Agreement as to Payment
16 of Compensation (G.S. §97-82)

17

18 IC File # _____
19 Emp. Code # _____
20 Carrier Code # _____
21 Carrier File # _____
22 Employer FEIN _____

23

24 ~~The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act~~

25

26 _____

27 Employee's Name

28 _____

29 Address

30 _____

31 City _____ State _____ Zip _____

32 _____

33 Home Telephone _____ Work Telephone _____

34 Social Security Number: _____ Sex: M F Date of Birth: _____

35

36 _____

37 Employer's Name _____ Telephone Number _____

1 _____
2 Employer's Address _____ City State Zip

3 _____
4 Insurance Carrier

5 _____
6 Carrier's Address _____ City State Zip

7 _____
8 Carrier's Telephone Number _____ Carrier's Fax Number

9 _____
10 We, The Undersigned, Do Hereby Agree and Stipulate As Follows:

11 1. _____ Date of injury: _____

12 2. _____ The employee returned to work / was rated on _____ (date), at a weekly wage of \$ _____.

13 3. _____ The employee became totally disabled on _____.

14 4. _____ Employee's average weekly wage was reduced / was increased on _____, from \$ _____
15 per week to \$ _____ per week.

16 5. _____ The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate
17 of \$ _____ per week.

18 Beginning _____, and continuing for _____ weeks. The type of disability compensation is
19 _____.

20 6. _____ State any further matters agreed upon, including disfigurement or temporary partial disability:
21 _____.

22 7. _____ IMPORTANT NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agreement
23 is \$300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your portion of
24 the fee in advance, and if your award is \$3,000.00 or less, you are not responsible for any portion of the fee. If your
25 award is more than \$3,000.00, the employer shall deduct \$150.00 from your award, unless you and your employer
26 agree otherwise.

27 Check one of the boxes below if the award is more than \$3,000.00:

28 The employer will deduct \$150.00 from the amount to be paid pursuant to this agreement.

29 The employee and employer have agreed that the employer will pay the entire fee.

30 _____
31 8. _____ The date of this agreement is _____.

32 _____
33 Name Of Employer _____ Signature _____ Title

34 _____
35 Name Of Carrier/Administrator _____ Signature _____ Title

36

1 By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on
2 Pages 1 and 2 of this form.

3 _____
4 Signature of Employee _____ Address

5 _____
6 Signature of Employee's Attorney _____ Address

7
8 Check box if no attorney retained.

9
10 North Carolina Industrial Commission

11 The Foregoing Agreement Is Hereby Approved:

12 _____
13 Claims Examiner _____ Date

14 _____
15 Attorney's fee approved

16
17 ~~IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM~~
18 ~~PAYMENTS~~

19 ~~Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial~~
20 ~~Commission in writing within two years from the date of receipt of your last compensation check or your rights to~~
21 ~~these benefits may be lost.~~

22
23 ~~IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL~~
24 ~~MEDICAL BENEFITS~~

25 ~~If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably~~
26 ~~necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.~~

27
28 ~~IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL~~
29 ~~MEDICAL BENEFITS~~

30 ~~If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several~~
31 ~~factors. Your right to payment of future medical compensation will terminate two years after your employer or~~
32 ~~carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think~~
33 ~~you will need future medical compensation, you must apply to the Industrial Commission in writing within two years,~~
34 ~~or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M, Employee's~~
35 ~~Application for Additional Medical Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>.~~

36
37 ~~IMPORTANT NOTICE TO EMPLOYER~~

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37

~~This form shall be used only to supplement Form 21, Agreement for Compensation for Disability (G.S. 97-82), or an award in cases in which subsequent conditions require a modification of a former agreement or award. The employee must be provided a copy of the form when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.~~

~~NEED ASSISTANCE?~~

~~If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.~~

~~Form 26
11/2014~~

~~Self-Insured Employer or Carrier Mail to:
NCIC - Claims Administration
4335 Mail Service Center
Raleigh, North Carolina 27699-4335
Main Telephone: (919) 807-2500
Helpline: (800) 688-8349
Website: <http://www.ic.nc.gov/>~~

(a) ~~(Effective July 1, 2015)~~ If the parties to a workers' compensation claim have previously entered into an approved agreement on a Form 21, *Agreement for Compensation for Disability*, or a Form 26A, *Employer's Admission of Employee's Right to Permanent Partial Disability*, they shall use the following Form 26, *Supplemental Agreement as to Payment of Compensation*, for agreements regarding subsequent additional disability and payment of compensation pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26, *Supplemental Agreement as to Payment of Compensation*, shall read as follows:

North Carolina Industrial Commission
Supplemental Agreement as to Payment
of Compensation (G.S. §97-82)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name

Address

City State Zip

Home Telephone

Work Telephone

Last 4 digits of Social Security Number: _____ Sex: M F Date of Birth: _____

Employer's Name

Telephone Number

Employer's Address

City State Zip

Insurance Carrier

Carrier's Address

City State Zip

Carrier's Telephone Number

Carrier's Fax Number

We, The Undersigned, Do Hereby Agree and Stipulate As Follows:

1. Date of injury: _____.

2. The employee returned to work / was rated on _____ (date), at a weekly wage of \$ _____.

3. The employee became totally disabled on _____.

4. Employee's average weekly wage was reduced / was increased on _____, from \$ _____ per week to \$ _____ per week.

1 5. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of
2 \$_____ per week.

3 Beginning _____, and continuing for _____ weeks. The type of disability compensation is
4 _____.

5 6. State any further matters agreed upon, including disfigurement or temporary partial disability:
6 _____.

7
8 7. The date of this agreement is _____.

9
10 Name Of Employer Signature Title

11 _____
12 Name Of Carrier/Administrator Signature Title

13
14 By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on
15 Page 2 of this form.

16 _____
17 Signature of Employee Address

18 _____
19 Signature of Employee's Attorney Address

20
21 Check box if no attorney retained.

22
23 North Carolina Industrial Commission
24 The Foregoing Agreement Is Hereby Approved:

25 _____
26 Claims Examiner Date

27 _____
28 Attorney's fee approved

29
30 IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM
31 PAYMENTS

32 Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial
33 Commission in writing within two years from the date of receipt of your last compensation check or your rights to
34 these benefits may be lost.

35
36 IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL
37 MEDICAL BENEFITS

1 If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably
2 necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

3
4 **IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL**
5 **MEDICAL BENEFITS**

6 If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several
7 factors. Your right to payment of future medical compensation will terminate two years after your employer or
8 carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think
9 you will need future medical compensation, you must ~~apply to the Industrial Commission in writing~~ file an application
10 for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be
11 lost. ~~To apply you may also use Industrial Commission Form 18M, Employee's Application for Additional Medical~~
12 ~~Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>.~~ An application for additional medical
13 compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by
14 written request. In the alternative, an employee may file an application for additional medical compensation by filing
15 a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission
16 forms are available at <https://www.ic.nc.gov/forms.html>.

17
18 **IMPORTANT NOTICE TO EMPLOYER**

19
20 This form shall be used only to supplement Form 21, *Agreement for Compensation for Disability* (G.S. 97-82), or an
21 award in cases in which subsequent conditions require a modification of a former agreement or award. The employee
22 must be provided a copy of the form when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A
23 .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator
24 must submit the agreement to the Industrial Commission. ~~Commission, or show cause for not submitting the~~
25 ~~agreement.~~ The employer or carrier/administrator shall file a Form 28B, *Report of Compensation and Medical*
26 *Compensation Paid*, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

27
28 **NEED ASSISTANCE?**

29
30 If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at
31 (800) 688-8349.

32 Form 26

34 7/2015/2020

35
36 Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"); ~~Carrier Mail to:~~
37 ~~NCIC Claims Administration~~

1 ~~4335 Mail Service Center~~
2 ~~Raleigh, North Carolina 27699-4335~~
3 ~~Main Telephone: (919) 807-2500~~
4 ~~Helpline: (800) 688-8349~~
5 ~~Website: <http://www.ic.nc.gov/>~~
6 ~~<https://www.ic.nc.gov/docfiling.html>~~

7 Contact Information:
8 NCIC- Claims Administration
9 Telephone: (919) 807-2502
10 Helpline: (800) 688-8349
11 Website: <https://www.ic.nc.gov>

12

13 (b) The copy of the form described in Paragraph (a) of this Rule can be accessed at
14 ~~<http://www.ic.nc.gov/forms/form26.pdf>~~~~<https://www.ic.nc.gov/forms/form26.pdf>~~. The form may be reproduced only
15 in the format available at ~~<http://www.ic.nc.gov/forms/form26.pdf>~~ ~~<https://www.ic.nc.gov/forms/form26.pdf>~~ and may
16 not be altered or amended in any way.

17

18 *History Note: Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
19 *Eff. November 1, 2014;*
20 *Recodified from 04 NCAC 10L .0102 Eff. June 1, 2018;*
21 *Amended Eff. _____.*

22

23

1 11 NCAC 23L .0103 is proposed for amendment as follows:

2

3 **11 NCAC 23L .0103 FORM 26A – EMPLOYER’S ADMISSION OF EMPLOYEE’S RIGHT TO**
4 **PERMANENT PARTIAL DISABILITY**

5 ~~(a) (Effective until July 1, 2015)The parties to a workers' compensation claim shall use the following Form 26A,~~
6 ~~Employer's Admission of Employee's Right to Permanent Partial Disability, for agreements regarding the employee's~~
7 ~~entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31.~~
8 ~~Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to~~
9 ~~G.S. 97-30, may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where~~
10 ~~applicable. The Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, shall read as~~
11 ~~follows:~~

12

13 *North Carolina Industrial Commission*
14 *Employer's Admission of Employee's Right to Permanent Partial Disability*
15 *(G.S. §97-31)*

16

17 *IC File # _____*
18 *Emp. Code # _____*
19 *Carrier Code # _____*
20 *Carrier File # _____*
21 *Employer FEIN _____*

22

23 *The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act*

24

25 _____

26 *Employee's Name*

27 _____

28 *Address*

29 _____

30 *City _____ State _____ Zip _____*

31 _____

32 *Home Telephone _____ Work Telephone _____*

33 *Social Security Number: _____ Sex: M F Date of Birth: _____*

34

35 _____

36 *Employer's Name _____ Telephone Number _____*

37 _____

1 ~~Employer's Address _____ City State Zip~~

2 _____

3 ~~Insurance Carrier~~

4 _____

5 ~~Carrier's Address _____ City State Zip~~

6 _____

7 ~~Carrier's Telephone Number _____ Carrier's Fax Number~~

8

9 ~~WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:~~

10 ~~1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and~~
11 ~~_____ is the Carrier/Administrator for the Employer.~~

12 ~~2. The employee sustained an injury by accident or the employee contracted an occupational disease arising~~
13 ~~out of and in the course of employment on _____.~~

14 ~~3. The injury by accident or occupational disease resulted in the following injuries:~~
15 ~~_____.~~

16 ~~4. The employee was was not paid for the 7 day waiting period.~~
17 ~~If not, was salary continued? yes no. Was employee paid for the date of injury? yes no~~

18 ~~5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances,~~
19 ~~was \$ _____. This results in a weekly compensation rate of \$ _____.~~

20 ~~6. The employee has has not returned full time to work for _____~~
21 ~~on _____, at an average weekly wage of \$ _____.~~

22 ~~7. Claimant was released with permanent restrictions without permanent restrictions.~~

23 ~~8. Permanent partial disability compensation will be paid to the injured worker as follows:~~
24 ~~_____ weeks of compensation at rate of \$ _____ per week for _____ % rating to _____ (body part)~~

25 ~~_____ weeks of compensation at rate of \$ _____ per week for _____ % rating to _____ (body part)~~

26 ~~_____ weeks of compensation at rate of \$ _____ per week for _____ % rating to _____ (body part)~~

27 ~~Total amount of permanent partial disability compensation is \$ _____. Date of first~~
28 ~~payment: _____.~~

29 ~~9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial~~
30 ~~disability, _____ waiting _____ period _____ or _____ other:~~

31 ~~_____.~~

32 ~~10. An overpayment is claimed in the amount of \$ _____. Overpayment was calculated as~~
33 ~~follows: _____.~~

34 ~~If overpayment claimed, a Form 28B, Report of Compensation and Medical Compensation Paid, is attached. yes~~
35 ~~no~~

36 ~~11. If applicable, the Second Injury Fund Assessment is \$ _____. A check is is not~~
37 ~~included.~~

1 ~~12. IMPORTANT NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agreement is~~
2 ~~\$300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your portion of the~~
3 ~~fee in advance, and if your award is \$3,000.00 or less, you are not responsible for any portion of the fee. If your award~~
4 ~~is more than \$3,000.00, the employer shall deduct \$150.00 from your award, unless you and your employer agree~~
5 ~~otherwise.~~

6 ~~Check one of the boxes below if the award is more than \$3,000.00:~~

7 ~~The employer will deduct \$150.00 from the amount to be paid pursuant to this agreement.~~

8 ~~The employee and employer have agreed that the employer will pay the entire fee.~~

9
10 ~~The undersigned hereby certify that the material medical and vocational reports related to the injury have been~~
11 ~~provided to the employee or the employee's attorney and have been filed with the Industrial Commission for~~
12 ~~consideration pursuant to G.S. 97-82(a) and Rule 11 NCAC 23A .0501.~~

13
14 _____
15 *Name Of Employer* _____ *Signature* _____ *Title* _____ *Date*

16 _____
17 *Name Of Carrier/Administrator* _____ *Signature* _____ *Direct Phone Number* _____ *Title* _____ *Date*

18
19 ~~By signing I enter into this agreement and certify that I have read the "Important Notices to Employee"~~
20 ~~printed on pages 2 and 3 of this form.~~

21
22 _____
23 *Signature of Employee* _____ *Address* _____ *Date*

24 _____
25 *Signature of Employee's Attorney* _____ *Address* _____ *Date*

26
27 ~~Check box if no attorney retained.~~

28
29 ~~North Carolina Industrial Commission~~
30 ~~The Foregoing Agreement Is Hereby Approved:~~

31 _____
32 *Claims Examiner* _____ *Date*

33 _____
34 *Attorney's fee approved*

35
36 ~~IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS~~

1 ~~Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial~~
2 ~~Commission in writing within two years from the date of receipt of your last compensation check or your rights to~~
3 ~~these benefits may be lost.~~

4
5 ~~IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL~~
6 ~~BENEFITS~~

7 ~~If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably~~
8 ~~necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.~~

9
10 ~~IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL~~
11 ~~MEDICAL BENEFITS~~

12 ~~If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several~~
13 ~~factors. Your right to payment of future medical compensation will terminate two years after your employer or~~
14 ~~carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think~~
15 ~~you will need future medical compensation, you must apply to the Industrial Commission in writing within two years,~~
16 ~~or your right to these benefits may be lost. To apply you may also use Industrial Commission 18M, Employee's~~
17 ~~Application for Additional Medical Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>.~~

18
19 ~~IMPORTANT NOTICE TO EMPLOYER~~

20 ~~The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC~~
21 ~~23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or~~
22 ~~carrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the~~
23 ~~agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical~~
24 ~~Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.~~

25
26 ~~NEED ASSISTANCE?~~

27 ~~If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at~~
28 ~~(800) 688-8349.~~

29
30 ~~Form 26A~~

31 ~~11/2014~~

32
33 ~~Self Insured Employer or Carrier Mail to:~~

34 ~~NCIC—Claims Administration~~

35 ~~4335 Mail Service Center~~

36 ~~Raleigh, North Carolina 27699-4335~~

37 ~~Main Telephone: (919) 807-2500~~

1 ~~Helpline: (800) 688-8349~~
2 ~~Website: http://www.ic.nc.gov/~~

3
4 (a) ~~(Effective July 1, 2015)~~ The parties to a workers' compensation claim shall use the following Form 26A,
5 *Employer's Admission of Employee's Right to Permanent Partial Disability*, for agreements regarding the employee's
6 entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31.
7 Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to
8 G.S. 97-30, may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501,
9 where applicable. The Form 26A, *Employer's Admission of Employee's Right to Permanent Partial Disability*, shall
10 read as follows:

11
12 North Carolina Industrial Commission
13 Employer's Admission of Employee's Right to Permanent Partial Disability
14 (G.S. §97-31)
15
16 IC File # _____
17 Emp. Code # _____
18 Carrier Code # _____
19 Carrier File # _____
20 Employer FEIN _____

21
22 The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

23
24 _____
25 Employee's Name
26 _____
27 Address
28 _____
29 City State Zip
30 _____
31 Home Telephone Work Telephone
32 Last 4 digits of Social Security Number: _____ Sex: M F Date of Birth: _____

33
34 _____
35 Employer's Name Telephone Number
36 _____
37 Employer's Address City State Zip

1 _____

2 Insurance Carrier

3 _____

4 Carrier's Address City State Zip

5 _____

6 Carrier's Telephone Number Carrier's Fax Number

7

8 WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:

9 1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and
10 _____ is the Carrier/Administrator for the Employer.

11 2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out
12 of and in the course of employment on _____.

13 3. The injury by accident or occupational disease resulted in the following injuries:
14 _____.

15 4. The employee was was not paid for the 7 day waiting period.
16 If not, was salary continued? yes no. Was employee paid for the date of injury? yes no

17 5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances,
18 was \$ _____. This results in a weekly compensation rate of \$ _____.

19 6. The employee has has not returned full time to work for _____
20 on _____, at an average weekly wage of \$ _____.

21 7. Claimant was released with permanent restrictions without permanent restrictions. *If claimant was*
22 *released with permanent restrictions and has returned to work for the employer of injury, attach a job description if*
23 *known to exist.*

24 8. Permanent partial disability compensation will be paid to the injured worker as follows:
25 _____ weeks of compensation at rate of \$ _____ per week for _____% rating to _____ (body part)
26 _____ weeks of compensation at rate of \$ _____ per week for _____% rating to _____ (body part)
27 _____ weeks of compensation at rate of \$ _____ per week for _____% rating to _____ (body part)

28 Total amount of permanent partial disability compensation is \$ _____. Date of first payment: _____.

29 9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial
30 disability, _____ waiting _____ period _____ or _____ other:
31 _____.

32 10. An overpayment is claimed in the amount of \$ _____. Overpayment was calculated as
33 follows: _____.

34 If overpayment claimed, a Form 28B, *Report of Compensation and Medical Compensation Paid*, is attached. yes
35 no

36 11. If applicable, the Second Injury Fund Assessment is \$ _____. A check is is not
37 included.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36

The undersigned hereby certify that the material medical and vocational ~~reports~~ records related to the ~~injury~~ injury, including any job description known to exist if the employee has permanent restrictions and has returned to work for the employer of injury, have been provided to the employee or the employee's attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. 97-82(a) and Rule 11 NCAC 23A .0501.

Name Of Employer	Signature	Title	Date
------------------	-----------	-------	------

Name Of Carrier/Administrator	Signature	Direct Phone Number	<u>Email Address</u>	Title	Date
-------------------------------	-----------	---------------------	----------------------	-------	------

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 3 of this form.

Signature of Employee	Address	<u>Email Address</u>	Date
-----------------------	---------	----------------------	------

Signature of Employee's Attorney	Address	<u>Email Address</u>	Date
----------------------------------	---------	----------------------	------

Check box if no attorney retained.

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

Claims Examiner	Date
-----------------	------

Attorney's fee approved

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

1 If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably
2 necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

3
4 **IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL
5 MEDICAL BENEFITS**

6 If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several
7 factors. Your right to payment of future medical compensation will terminate two years after your employer or
8 carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think
9 you will need future medical compensation, you must ~~apply to the Industrial Commission in writing~~ file an application
10 for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be
11 lost. ~~To apply you may also use Industrial Commission 18M, Employee's Application for Additional Medical~~
12 ~~Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>.~~ An application for additional medical
13 compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by
14 written request. In the alternative, an employee may file an application for additional medical compensation by filing
15 a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission
16 forms are available at <https://www.ic.nc.gov/forms.html>.

17
18 **IMPORTANT NOTICE TO EMPLOYER**

19 The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC
20 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or
21 carrier/administrator must submit the agreement to the Industrial ~~Commission~~ Commission, ~~or show cause for not~~
22 ~~submitting the agreement.~~ The employer or carrier/administrator shall file a Form 28B, *Report of Compensation and*
23 *Medical Compensation Paid*, within 16 days after the last payment made pursuant to this agreement or be subject to
24 a penalty.

25
26 **NEED ASSISTANCE?**

27 If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at
28 (800) 688-8349.

29
30 Form 26A

31 ~~7/2015 6/2020~~ 7/2020

32
33 Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"); Carrier Mail to:
34 ~~NCIC—Claims Administration~~
35 ~~4335 Mail Service Center~~
36 ~~Raleigh, North Carolina 27699-4335~~
37 ~~Main Telephone: (919) 807-2500~~

1 ~~Helpline: (800) 688-8349~~
2 ~~Website: <http://www.ic.nc.gov/>~~
3 <https://www.ic.nc.gov/docfiling.html>
4 Contact Information:
5 NCIC- Claims Administration
6 Telephone: (919) 807-2502
7 Helpline: (800) 688-8349
8 Website: <https://www.ic.nc.gov>

9
10 (b) A copy of the form described in Paragraph (a) of this Rule can be accessed at
11 <http://www.ic.nc.gov/forms/form26a.pdf><https://www.ic.nc.gov/forms/form26a.pdf>. The form may be reproduced
12 only in the format available at <http://www.ic.nc.gov/forms/form26a.pdf><https://www.ic.nc.gov/forms/form26a.pdf> and
13 may not be altered or amended in any way.

14
15 *History Note: Authority G.S. 97-30; 97-31; 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
16 *Eff. November 1, 2014;*
17 *Recodified from 04 NCAC 10L .0103 Eff. June 1, 2018;*
18 *Amended Eff. _____;*
19 *Amended Eff. _____.*

20

1 11 NCAC 23L .0105 is proposed for amendment as follows:

2

3 **11 NCAC 23L .0105 FORM T-42 – APPLICATION FOR APPOINTMENT OF GUARDIAN AD LITEM**

4 (a) Persons seeking to appear on behalf of an infant or incompetent shall apply on a Form T-42, Application for
5 Appointment of Guardian Ad Litem, in accordance with Rule 11 NCAC 23B .0203. The Form T-42, Application for
6 Appointment of Guardian Ad Litem, shall read as follows:

7

8 North Carolina Industrial Commission

9 IC File # TA- _____

10 Application for Appointment of Guardian Ad Litem

11 The use of this Form is required under Rule 11 NCAC 23B .0203

12

13 _____ Plaintiff(s) v. _____ Defendant(s)

14

15 To the North Carolina Industrial Commission:

16

17 The undersigned _____ respectfully shows unto the North Carolina Industrial Commission that _____ is
18 an __ infant or __ incompetent without general or testamentary guardian in this State, and that by reason thereof can
19 bring an action only by a guardian ad litem; that the infant or incompetent has a cause of action against the defendants
20 on account of the following matter and things:

21 _____

22 The undersigned is a reputable person closely connected with the infant or incompetent having the relationship with
23 the infant or incompetent as follows: _____

24

25 Wherefore, the undersigned prays the Commission that a fit and proper person be appointed Guardian Ad Litem for
26 the infant or incompetent for the purpose of bringing on his or her behalf an action as above set out.

27 Signature of Applicant _____ Date _____

28

29 (Please complete page 2 of form)

30

31 Order Appointing Guardian Ad Litem

32

33 It appearing to the North Carolina Industrial Commission from the above application that _____ is
34 an __ infant or __ incompetent having no general or testamentary guardian within this State and that said infant or
35 incompetent appears to have a good cause of action against the defendant(s); and it further appearing to the
36 Commission after due inquiry that _____ is a fit and proper person to be appointed guardian ad
37 litem for the infant or incompetent for the purpose of bringing this action on his or her behalf;

1 It is therefore ordered that _____ be and is hereby appointed guardian ad litem of
2 _____ to bring action on his or her behalf.

3

4 This _____ day of _____.

5

6 ~~Commissioner or Deputy Commissioner~~ Commissioner, Deputy Commissioner, or Executive Secretary

7 _____

8

9 Please type or print:

10

11 Full name and address of minor or incompetent:

12 _____

13 Birth date of minor: _____

14 Full name and address of proposed guardian ad litem:

15 _____

16

17 Important Information for Parties

18 Parties should take notice of the provisions set forth in Rule 11 NCAC 23B .0203.

19

20 11 NCAC 23B .0203 Infants and Incompetents

21 (a) Persons seeking to appear on behalf of an infant or incompetent, in accordance with G.S. 1A-1, Rule 17, shall
22 apply on a Form T-42 Application for Appointment of Guardian ad Litem. The Commission shall appoint a fit and
23 proper person as guardian ad litem, if the Commission determines it to be in the best interest of the minor or
24 incompetent. The Commission shall appoint the guardian ad litem only after due inquiry as to the fitness of the person
25 to be appointed.

26 (b) The Commission may assess a fee to be paid to an attorney who serves as a guardian ad litem for actual services
27 rendered upon receipt of an affidavit of actual time spent in representation of the minor or incompetent as part of the
28 costs.

29

30 **ATTORNEYS:** File via Electronic Document Filing Portal (“EDFP”)

31 <https://www.ic.nc.gov/docfiling.html>

32 **UNREPRESENTED PLAINTIFFS:** File via EDPF, <https://www.ic.nc.gov/docfiling.html> OR

33 Mail to: Industrial Commission Clerk’s Office, 1236 Mail Service Center, Raleigh NC 27699-1236 OR

34 File via hand delivery: Business days from 8 a.m. – 5 p.m., Dobbs Building, 6th floor, 430 N. Salisbury Street,

35 Raleigh NC 27603.

36

37 **SEND TO:** _____

1 ~~dockets@ic.nc.gov~~
2 ~~Office of the Clerk~~
3 ~~1236 Mail Service Center~~
4 ~~Raleigh, NC 27699 1236~~
5 ~~Main telephone: (919) 807 2500~~
6 ~~Helpline (800) 688 8349~~
7 ~~Website: http://www.ic.nc.gov~~

8

9 FORM T-42

10

11 (b) A copy of the form described in Paragraph (a) of this Rule can be accessed at
12 ~~<http://www.ic.nc.gov/formt42.pdf>~~ <https://www.ic.nc.gov/forms/formt-42.pdf>. The form shall be reproduced only in
13 the format available at ~~<http://www.ic.nc.gov/forms/formt42.pdf>~~ <https://www.ic.nc.gov/forms/formt-42.pdf> and shall
14 not be altered or amended in any way.

15

16 *History Note: Authority G.S. 143-291; 143-295; 143-300;*
17 *Eff. March 1, 2019;*
18 *Amended Eff. _____.*

19

20